SAVE PRINT CLEAR

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR:

Employer (name of firm)_____ is offering you the position of a

(name of job) .

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____ Date job starts: _____.

Claims Administrator:_____Claim Number:

NOTICE TO EMPLOYEE Name of employee: _____

Date of Injury: Date offer received:

You have 30 calendar days from receipt to accept or reject the attached offer of modified or alternative work. Regardless of whether you accept or reject this offer, the remainder of your permanent disability payments may be decreased by 15%. However, if you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless:

Modified Work ☐ **or Alternative Work** ☐

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered are less than 85% paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

☐ I accept this offer of Modified or Alternative work.

☐ I reject this offer of Modified or Alternative work and understand that I am not entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

_____ Date

Signature

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is <u>not</u> accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Administrative Director within 30 days of acceptance or rejection. (A.D., "SJDB," Division of Workers' Compensation, P.O. Box 420603, S.F., CA 94102-3660)
If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

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POSITION REQUIREMENTS

Actual job title:

Wages: $ per Hour ☐ Week ☐ Month ☐

Is salary of modified/alternative work the same as pre-injury job? Yes ☐ No ☐

Is salary of modified/alternative work at least 85% of pre-injury job? Yes ☐ No ☐

Will job last at least 12 months? Yes ☐ No ☐

Is the job a regular position required by the employer's business? Yes ☐ No ☐

Work location: _____

Duties required of the position:

Description of activities to be performed (if not stated in job description):

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional): Date of report:: _____

Date of last payment of Temporary Total Disability:

Preparer's Name: _____

Preparer's Signature: Date